

751

## CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Millington</i>				c. LENGTH OF STAY IN 1b <i>1 x 2 1/2 Millington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>M</i> Last <i>ATKINSON</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>3</i> Year <i>1957</i>			
5. SEX <i>male</i>	6. COLOR OF RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1889</i>	9. AGE (In years last birthday) <i>67</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>7</i> Hours <i>0</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Linted Farm</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jessie Atkinson</i>				14. MOTHER'S MAIDEN NAME <i>Hannah M. E. Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-34-6107</i>		17. INFORMANT <i>Kenneth Atkinson Millington, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Insufficiency</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>bronchectasis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office, etc.) <i>Home</i>	
				20f. (City or town) <i>Millington</i>		20g. (County) <i>md.</i>	
				20h. (State) <i>md.</i>			
21. I certify that I attended the deceased from <i>12/12/56</i> , 19 <i>56</i> , to <i>1/3/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/14/56</i> , 19 <i>56</i> , and that death occurred at <i>10:30</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. H. Hamilton</i>				DATE SIGNED <i>1/5/57</i>			
PHYSICIAN'S NAME (Type) <i>H. H. Hamilton</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Jan 6, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Rock Hall, md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edmond Vellor</i>				24a. REC'D BY REGISTRAR <i>Jan 9 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Ely. Mulford</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

003422

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b. <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>533 High st.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>533 High st.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisy</b> First <b>O.</b> Middle <b>Barnes</b> Last		4. DATE OF DEATH <b>January</b> Month <b>7</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sec'y.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bookeeping</b>	11. BIRTHPLACE (State or foreign country) <b>Chestertown</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John W. Barnes</b>	
14. MOTHER'S MAIDEN NAME <b>Sahah Crouch</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-03-8134</b>		17. INFORMANT <b>Earle Barnes, Chestertown, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable coronary thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Short</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		DATE SIGNED <b>Jan. 8, 1957</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/9/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>		24a. REC'D BY REGISTRAR <b>Jan. 10-57</b> 24b. REGISTRAR'S SIGNATURE <b>Class L. Barnes</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 14 1957  
BUREAU V. E.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 747

### CERTIFICATE OF DEATH

00743

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. LENGTH OF STAY IN 1b <b>16 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 CHESTERTOWN</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1204 Calvert Street</b>			
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>LOUISE</b> Last <b>BOWSER</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 11, 1895</b>		9. AGE (In years last birthday) yrs. <b>61</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>GEORGE DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE LEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>HOSPITAL CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>561.2</b> <b>INTESTINAL OBSTRUCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>STRANGULATED UMBILICAL HERNIA</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
20f. (City or town) _____							
21. I certify that I attended the deceased from <b>JAN 10, 1957</b> to <b>JAN 11, 1957</b> , that I last saw the deceased alive on <b>JAN 11, 1957</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, Md</b> DATE SIGNED <b>1-11-57</b>							
ACTUAL SIGNATURE <b>A. T. Keefe, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>A. T. KEEFE, JR. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Jan. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near Galena - Kent Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan. 14-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>			



CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

BUREAU V. S.

JAN 16 1957

RECEIVED

752

## CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Worton</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Boyer</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1886</b>	9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months <b>29</b>	IF UNDER 24 HRS. Days <b>19</b>	Hours <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Samuel L. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Gertrude Johnson, Worton, R.F.D. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sensibility</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January, 1956</b> , to <b>January, 1957</b> , that I last saw the deceased alive on <b>January 21, 1957</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall, Maryland</b> DATE SIGNED <b>Jan 29/57</b>							
ACTUAL SIGNATURE <b>E. Kester</b> M.D.				PHYSICIAN'S NAME (Type) <b>Eugene Kester</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Worton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor M. Kennedy</b>				ADDRESS <b>Still Pond, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>1/31/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>E. Kennedy Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

FEB 4 1957

RECEIVED

Walter H. [illegible]



## 753 CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Worton</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Brooks</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24. 1955</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Bernard Brooks</b>	
14. MOTHER'S MAIDEN NAME <b>Helen Dorsey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Aldridge Dorsey Worton, R. D. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> DUE TO (b) <b>Congenital heart disease</b> DUE TO (c) <b>generalized poor protoplasm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>lifetime</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>poor assimilation of food</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>birth</b> 19 <b>Jan 20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 18</b> , 19 <b>57</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Florence D. Joyce</b> M.D.		ADDRESS (Street, city or town, state) <b>Worton, Md.</b> DATE SIGNED <b>1-21-57</b>	
PHYSICIAN'S NAME (Type) <b>Florence D. Joyce</b>		<b>Worton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-20-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Coleman Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Worton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		ADDRESS <b>Still Pond, Md.</b>	
24a. REC'D BY REGISTRAR <b>1/21/56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Kennedy Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

born [illegible] of [illegible]  
 General West [illegible]  
 General West [illegible]

RECEIVED  
 JAN 28 1957  
 BUREAU V. S.  
 27  
 1044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

748

## CERTIFICATE OF DEATH

00746

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesler Town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent &amp; Queen Anne's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carter</u>				4. DATE OF DEATH Month Day Year <u>January 20 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 29 1957</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald Harper Carter</u>				14. MOTHER'S MAIDEN NAME <u>Alta Elizabeth Stowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>Worton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>57</u> , to <u>1-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>57</u> , and that death occurred at <u>5:15</u> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Chesler Town, Md.</u> PHYSICIAN'S NAME (Type) <u>[Signature]</u> <u>Chesler Town, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-21-57</u>		<u>STILL POND CEMT</u>		<u>STILL POND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>1/21/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. S.

JAN 23 1957

RECEIVED

U. S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

2-1-57

754

## CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROBBINS NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>CLARK</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17, 1872</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHANIEL H. CLARK</u>				14. MOTHER'S MAIDEN NAME <u>MARY SEENEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W.C. HOLDEN</u>		Address <u>Box 6, DOVER, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>year</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>196X Cancer L jaw</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>3/25/50</u> , 19 <u>  </u> , to <u>1/7/57</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>57</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Hamilton</u>				ADDRESS (Street, city or town, state) <u>Millington, Ind.</u>			
DATE <u>1/9/59</u>				DATE SIGNED <u>1/9/59</u>			
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>				DATE <u>1/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, O.A. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>				ADDRESS <u>Millington, Ind.</u>		24a. REC'D BY REGISTRAR <u>JAN 1</u>	
24b. REGISTRAR'S SIGNATURE <u>Ely. Mulford</u>				DATE <u>1/9/59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

755

CERTIFICATE OF DEATH

Reg. Dist. No.

00748

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAGGIE</u> Middle <u>G.</u> Last <u>COLEMAN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 - 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN GRULSKY</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. MILTON GLENN</u>		Address <u>ROCK HALL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 18, 1952</u> to <u>Jan. 19, 1957</u> , that I last saw the deceased alive on <u>Jan. 18, 1957</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard J. Smith</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Rock Hall, Md. 1/24/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JAN. 22</u>	<u>WESLEY CHAPEL</u>	<u>ROCK HALL MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard L. Lane - Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1/22/57</u>	24b. REGISTRAR'S SIGNATURE <u>Severed Rogers</u>

BUREAU V. S.

JAN - 1 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

756

## CERTIFICATE OF DEATH

00749

Reg. Dist. No. 203

1. PLACE OF DEATH o. COUNTY <u>Rock Hall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>dent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elva</u> Middle <u>Mary</u> Last <u>Conner</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15-1888</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Unborn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	17. INFORMANT Address <u>Miss Vernon Baker Rock Hall</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure &amp; pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease &amp; thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1, 1956</u> to <u>Jan. 14, 1957</u> , that I last saw the deceased alive on <u>Jan. 12, 1957</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>1/15/57</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>1/16/57</u>	24b. REGISTRAR'S SIGNATURE <u>D. Shinnock Banger</u>

RECEIVED  
JAN 21 1957  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00750

Reg. Dist. No.

200

757

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - galena</b>		c. LENGTH OF STAY IN 1b <b>Rock Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>FRANCES BENTON DU VALL</b>		4. DATE OF DEATH <b>January 9 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-1922</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raymond Benton</b>		14. MOTHER'S MAIDEN NAME <b>Helen Ann Vall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-14-9153</b>	
17. INFORMANT <b>R. Benson Ann Vall - Rock Hall Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple severe crushing injury</b> DUE TO <b>to chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>none</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased drove car on to driveway and collected with on company car was apparently thrown from car &amp; run over by other vehicle</b>	
20c. TIME OF INJURY Month, Day, Year <b>Jan 9 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway</b>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <b>Galena</b>		20f. (City or town) (County) (State) <b>Kent Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Robert W Farr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>ROBERT W FARR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar H. Kane - Church Hill, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 11 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Edg. Mulford</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with file registrar prior to burial, cremation, or removal.

BUREAU V. S.

N 1 1 1951

CLIVE

758  
CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH o COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>FREDERICK</b> Middle <b>JACOB</b> Last		4. DATE OF DEATH Month <b>JAN.</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 16 - 1894</b>
9. AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRAW-BRIDGE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HERMAN JACOB</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE KIRSNECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>#1 War.</b>		16. SOCIAL SECURITY NO. <b>220-32-978</b>	
17. INFORMANT <b>MRS. CHAS. JACOB - ROCK HALL MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Oedema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Cordis Vascular</b> DUE TO (c) <b>Coronary Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arterio sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 7</b> , 19 <b>55</b> , to <b>Jan 8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 7</b> , 19 <b>57</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert C Nitsch</b> M.D. <b>ROCK HALL</b>		ADDRESS (Street, city or town, state) <b>ROCK HALL MD</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT C NITSCH - ROCK HALL</b>		DATE SIGNED <b>Jan 9/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>JAN. 10</b>	22b. DATE THEREOF <b>JAN. 10</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL</b>	22d. LOCATION (City, town, or county) (State) <b>RURAL ROCK HALL MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Rane</b> ADDRESS <b>Church Hill</b>		24a. REC'D BY REGISTRAR <b>DATE 1/10/57</b>	24b. REGISTRAR'S SIGNATURE <b>S. S. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 15 1937

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00752

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

702

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MA ssey</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Annes</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) <b>Edward</b> First Middle Last <b>Johnson</b>				4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25, 1892</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Bushrod</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>216-18-8879</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cholecystitis, Gangrenousm acute</b> DUE TO (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Lower Nephron Nephrosis</b> PERICARDITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pericarditis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7-10 days</b> <b>7-10 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 12 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Bethel Am.</b>		22d. LOCATION (City, town, or county) (State) <b>Gallo Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Yellow</i>				ADDRESS <i>Millington Md.</i>		24a. REC'D BY REGISTRAR <b>Jan 14 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>Clara Barnes</i>			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

759

## CERTIFICATE OF DEATH

00753

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		c. LENGTH OF STAY IN 1b <b>10 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>JOYCE LANE</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>COLLISON</b> Middle <b>JOYCE</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE PRACT</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CYRUS NEWTON JOYCE</b>		14. MOTHER'S MAIDEN NAME <b>MARY COLLISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOHN RODGERS JOYCE JR</b>		Address <b>ARNOLD MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4331 VENTRICULAR FIBRILLATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>never</b> , 19____, and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>WORTON, Md</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>FLORENCE DERINGER JOYCE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Jan 5-1957</b>	<b>London Park</b>	<b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Baltimore</b>		24a. REC'D BY REGISTRAR <b>1/4/57</b>	
ADDRESS <b>2204 N. ...</b>		24b. REGISTRAR'S SIGNATURE <b>Clara J. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00754

760

## CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENNEDYVILLE Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENNEDYVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>MILLER</b> Last <b>JR</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1890</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min <b>66</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>RET. FARM OWNER</b>				11. BIRTHPLACE (State or foreign country) <b>KENT Co., Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES MILLER</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. MEIER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-34-9834</b>		17. INFORMANT <b>Charles E. MILLER</b>		Address <b>KENNEDYVILLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> <b>165X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEFT POSTERO LATERAL MYOCARDIAL INFARCT healed</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. ft. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>October, 1954</b> , to <b>Jan</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 21</b> , 19 <b>57</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D. <b>WORTON, Md</b> <b>1-25-57</b>							
PHYSICIAN'S NAME (Type) <b>FLORENCE DERINGER JOYCE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMT</b>		22d. LOCATION (City, town, or county) (State) <b>CHESTERTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor M. Kennedy</b>				ADDRESS <b>STILL POND, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>1/26/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>E. Kennedy Jones</b>			

RECEIVED

BUREAU V. S.

JAN 1952

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U. S. DEPT. OF JUSTICE



1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>			
				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>FREDERICK</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1882</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PENSIONED FIRE-MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Myers</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Kettler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>EMIL MYERS = ROCK HALL MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 1952</b> , 19____, to <b>Jan. 28, 1957</b> , that I last saw the deceased alive on <b>Jan. 21, 1957</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard J. Smith MD</b>				ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b>			
DATE SIGNED <b>1/28/57</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan. 30</b>		<b>Wesley Chapel</b>		<b>Rock Hall Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar A. Kane</b>				ADDRESS <b>Church Hill</b>		24a. REC'D BY REGISTRAR DATE <b>1/28/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>D. Howard Bungeas</b>			

BUREAU V. 5

JAN 31 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN life <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Vernon Ave.</u>		d. STREET ADDRESS <u>Mt. Vernon Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella M. Reiche</u>		4. DATE OF DEATH Jan. 1, 1957 Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1865</u>
9. AGE (In years last birthday) yrs. <u>91</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Davis</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. S.S. Smith</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>senility</u> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years at least</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>53</u> , to <u>Jan. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 2</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>I/2/57</u> ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert W. Farr - Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 4-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[REDACTED]

BUREAU V. 2

JAN 7 1957

RECEIVED